STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155688	A. BUILDING 00 B. WING	07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREELANDVILLE COMMUNITY HOME	310 W CARLISLE ST FREELANDVILLE, IN47535

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F0000	This visit was for a Recertification and State Licensure Survey Survey dates: July 10, 11, 12, 13, 14, 2011 Facility number: 000355 Provider number: 155688 AIM number: 100273640 Survey team: Liz Harper, RN, TC Carole McDaniel, RN, July 12, 13, 14, 2011 Terri Walters, RN, July 10, 12, 13, 14, 2011 Martha Saull, RN Census bed type: SNF/NF: 36 Census payor type: Medicare: 11 Medicaid: 17 Other: 8 Total: 36 Sample: 10 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on July 18,	F0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective August 13, 2011 to the annual licensure survey conducted on July 10, 2011 through July 14, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	2011 by Bev Faulkner, RN			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on observation, the facility failed to ensure resident care was provided in a manner to maintain dignity and respect for 2 of 3 residents observed for medication administration including glucose monitoring and involved 1 of 3 nurses observed. (LPN #4, Residents #10 and # 28) Findings include: On 7/12/11 at 10:55 A.M., LPN#4 was observed doing a blood glucose test for Resident #10. Resident #10 was approached for the finger stick to obtain blood while she was lying on a raised mat in the Therapy department. Resident #4 was seated doing exercises with a therapist and facing Resident #10. There was no visual or auditory barrier in use in use between the residents. Both Resident #4 and the therapist took a rest break and turned their attention to the performance of Resident #10's needle stick and the announcement of the test result and the	F0241	**F241 It is the practice of Freelandville Community Home to always assure that residents are respected and treated in a dignified manner.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Residents #10 and #28 are receiving insulin injection and/or eye drop administration in a manner that promotes dignity. All nurses have been in-serviced related to promoting dignity during medication pass. Other residents that have the potential to be affected have been identified by: All residents have been reviewed to assure that they each receive medications in a dignified manner. All nurses have been in-serviced related to promoting dignity during medication pass. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nurses have been in-serviced related to promoting dignity during	08/13/2011

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	need for an insulin shot before lunch for Resident #10. On 7/12/11 at 11:30 A.M., LPN #4 returned to therapy to administer the insulin shot to Resident # 10. In the therapy room at that time there was an Activity Department staffer and a Physical Therapy Assistant. Resident #10's insulin shot was administered into her bared abdomen. There was no privacy provided from exposure to uninvolved staff or the hallway where 2 visitors were standing. On 7/13/11 at 11:20 A.M., LPN #4 was observed administering eye drops to Resident #28. Resident #28 was a totally dependent resident in a Broda chair. The resident had been parked in the front lounge where 10 other residents and a visitor were all seated in circular fashion with 6 residents and the visitor facing Resident #28. Resident #35 was alert and awake and parked in front and to the right of Resident #28, head on with their faces approximately 8 feet away. LPN #4 had made her way to Resident #28 and directed "open your eyes now, lets open them for your drops." Resident #35 also directed aloud "Open up, (name of Resident #28) mmmm boy that's good." After the installation of the drops the nurse asked "Is that better now (name of Resident #28)? Resident #35, still		medication pass. The in-service included providing privacy while administering insulin injections and eye drops. It was reiterated to the nurses/QMA's the importance of assuring that medications are administered in a manner that enhances resident dignity and that procedures are not to be completed where the residents can be visualized by others. See below for means of monitoring to prevent reoccurrence.The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to medication pass. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed. In addition, nursing administration will be observing via routine rounds to assure that medication administration is provided in a dignified manner and that privacy is provided to the residents appropriately.The date the systemic changes will be completed: August 13, 2011	

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	engaged in the process, nodded her head to indicate yes. 3.1-3(t)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure treatment orders were followed to promote healing of pressure ulcers for 1 of 1 residents with observed dressing changes in a sample of 10. Resident #7 Findings include: The clinical record of Resident #7 was reviewed on 7/10/11 at 3:10 P.M. Diagnoses included, but were not limited	F0314	**F314 It is the practice of this facility to assure that the all residents receive the necessary care and services to prevent and treat pressure ulcers.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #7 has an appropriate treatment in place and the areas are improving and almost healed. ***Other residents that have the potential to be affected have been identified by:*** A house-wide review has been conducted to assure that	08/13/2011

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	to, the following: Spinal Stenosis, Edema, Peripheral Neuropathy, weakness, Congestive heart failure and Quadriplegia. The most recent MDS (Minimum Data Set) assessment, dated 6/10/11, indicated the following: independent cognition, stage II pressure ulcer (partial thickness loss of dermis present as shallow open ulcer) present on admission, totally dependent for bed mobility. The treatment sheet for June 2011 and July 2011 indicated the following treatment: "foam tegaderm to R (right) outer ankle changed every other day (QOD) et (and) prn (as needed) x (times) 14 days..." This order had an origination date of 6/28/11 and was documented as having been completed on the following dates: 6/29, 7/1, 7/3, 7/5, 7/7, 7/9, 7/11. Nurses notes, dated 7/6/11, indicated the following: "1 P.M. Area on top of foot R (right) side above little toe received sm (small) 0.5 cm (centimeter) ST (skin tear). Received N.O. (new order) Bactroban/Band-Aid, change daily x (times) 14 days or UH (until healed)." The treatment sheet for July 2011 was reviewed. The treatment received on 7/6/11 indicated the following: "Bactroban/Band-Aid to R (right) foot above little toe daily x 14 days uh (until		any resident that has altered skin integrity has been addressed. All residents that currently have pressure ulcers have been reviewed to assure that proper treatments and services are in place to assist with the healing of wounds. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Nurses have been in-serviced related to the prevention and/or treatment of pressure ulcers. The in-service includes assuring that treatments are completed in accordance with the physicians' orders. All nursing staff has been in-serviced related to identifying when treatments may have been removed or dislodged and the proper reporting mechanisms as well as the responsibility of the nurse to assure that the treatment is then reapplied appropriately. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to observe for the provision of wound care, assuring that treatment is in place per observation in accordance with the physician's orders. The tool will randomly review 5 residents (if applicable) to assure that proper interventions are in place related to the preventions and/or treatment of pressure ulcers. The	

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	healed)." The treatment sheet had initials from 7/6/11 to 7/12/11 indicating the treatment had been completed. The treatment sheet indicated the 11 - 7 (night shift) shift was to complete the treatments. On 7/12/11, the treatment was documented as having been completed twice. Initials indicated the night shift nurse completed the treatment and the day shift nurse on 7/12/11 also completed the treatment. On 7/11/11, the resident's care was observed at 9:15 A.M. She was observed to be in a specialty bed with a speciality antipressure mattress, which didn't have sheets on it. The resident was observed in her bed on her back. She had just been put back to bed via a Hoyer lift (mechanical lift used to move a resident from surface to surface) by CNA #1 and CNA #2. CNA #1 moved the resident's right leg. As CNA #1 moved the resident's right leg, a dressing was observed on the bed, near the foot of the bed, on the resident's right side. A Band-Aid was observed on the resident right outer foot, just below the level of the base of the small toe. CNA #1 stated "I'll have the nurse put the patch back on." CNA #1 then threw the dressing away and left the room. An open area, approximately the size of a pencil eraser, was observed to the resident's right lateral		Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** August 13, 2011	

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	ankle bone. At 11:05 A.M., Physical Therapy staff #1 was observed performing range of motion exercises on the resident's bilateral upper and lower extremities, while she was in her bed. At 11:50 A.M., CNA #3 and CNA #4 were observed getting the resident up with the Hoyer lift for lunch. CNA #3 stated "We'll have to get you a new Band-Aid for your foot." The Band-Aid was observed missing to the resident's right outer foot. A reddened area, approximately the size of pencil eraser, was observed just below the base of the small toe on the resident's right outer foot. No dressing was observed to the resident's right ankle at this time either. At 2:20 P.M., no Band-Aid or dressing was observed to the resident's right ankle and or outer foot. On 7/12/11 at 9:40 A.M., the resident was again observed in bed. She had a Band-Aid observed to her right lateral ankle and no Band-Aid observed to her right lateral foot. Upon request, LPN #2 removed the Band-Aid to the right lateral ankle. An open area approximately the size of a pencil eraser was observed. The reddened area to the resident's right outer			

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	foot was still observed. LPN #2 indicated the reddened area to the right outer foot as "not opened, scabbed over." On 7/12/11 at 12 P.M., the resident was observed with a dressing to her right outer ankle bone and a Band-Aid to her right outer foot. On 7/13/11 at 12 P.M., the Wound/Skin Nurse provided a current copy of the facility policy and procedure for Dressing Change (clean). This policy was documented as having been reviewed most recently on 10/1/10. The procedure included, but was not limited to, the following: "...apply prescribed medication if ordered, apply dressing and secure with tape..." On 7/14/11 at 9:45 A.M., the Wound/Skin Nurse was interviewed. She indicated that nursing should follow the physician orders regard the treatment and placement of dressings. 3.1-40(a)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure safety devices were in place for a resident with a recent fall resulting in a fracture for 1 of 5 residents with fall prevention interventions in a sample of 10. Resident # 19 Findings include: 1. On 7/11/11 at 10:45 A.M., the clinical record of Resident #19 was reviewed. Diagnoses included, but were not limited to, the following: The most recent MDS (Minimum Data Set) assessment, dated 5/19/11, indicated the following: moderately impaired cognition; required extensive assistance with transfers; limited assistance required for ambulation in room and corridor. Nurses notes, dated 6/7/11 at 5 A.M., indicated the following: "...Res (resident) found lying on floor...stated she got up to the restroom, the toilet kept running, res attempted to remove lid per self and fell on L(left) side..." Nurses notes, dated 7/3/11 at 5:15 A.M., indicated the following: "CNA (certified nursing assistant) found resident lying on the floor beside her bed, alarm sounding. Res. found lying on floor on left side..." At 1 P.M.: "...c/o (complained of) R (right) hip pain...send to ...ER (emergency room)...At 5:30 P.M.: Res admitted to (name of	F0323	**F323It is the practice of Freelandville Community Home to assure that all fall interventions are in place in accordance with the residents' plans of care** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #19 has been reviewed and has all appropriate fall prevention interventions in place in accordance with the plan of care. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that they are receiving services in accordance with the plan of care and assessed safety devices. The CNA assignment sheets appropriately address residents needs based on the assessment and a monitoring system has been implemented to assure that interventions are appropriately in place. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The interdisciplinary team will be	08/13/2011

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	hospital)..." A plan of care, dated most recently as 7/11/11, indicated the following: "At risk for falls r/t (related to) decreased mobility...transfers self at times...doesn't use call light at times...doesn't ask for assist with transfers at times..." Approaches included, but were not limited to, the following: "...alarm mat by bed (6/7/11)... mattress with built in bolsters 7/3/11..." On 7/11/11, the resident's care was observed. At 9:45 A.M., the resident was observed lying in her bed. An alarm box was observed at the head of the resident's bed with the attached cord connecting to the mat located on the floor beside the resident's bed. The resident's right side of her bed was against the wall. The alarm box was located on the resident's left side of the resident's bed. The resident 's bedside table was sitting with all four wheels on the mat. At 10:40 A.M., CNA #1 entered the resident's room and asked if she wanted ice. CNA #1 walked over to the resident's bedside and stood on the mat. No alarm was heard sounding. CNA #1 then went out of the room to get a pitcher. A cord was observed extending from underneath the resident's sheets down to the top of the alarmed floor mat. This cord was not attached to anything but lying on top of the mat. CNA #1 then again stood on the bedside floor mat, again with no alarm sounding. CNA #1 then backed off the bedside mat and pulled the bedside table off the mat. While standing on the mat, CNA #1 assisted the resident. When CNA #1 was done, she then backed off of the mat and replaced the bedside table to the mat, with all four wheels on the mat. Again no alarm sounded. She then bent over and took the loose end of the cord, which was lying unattached on top of the floor mat, and put it underneath the bed. She backed off the mat and		reviewing every fall to assure that appropriate interventions are in place based on the possible cause of the fall. The plan of care and the CNA assignment sheets will be updated as needed. The nursing staff has again been in-serviced related to providing services to our residents in correlation with the written plan of care. In addition, there will be additional emphasis for new CNA's related to reviewing their assignment sheets so that they are aware of the plan of care established for the resident. There will be routine monitoring via rounds by nurses and nursing administration to assure that safety devices are in place and functional in accordance with the residents' plan of care. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents' comprehensive assessment in correlation with the plan of care to assure that the pertinent information based on the assessment is accurately communicated and being followed in accordance with the residents' identified needs. Safety device placement and function will be specifically identified on the monitoring form. The Director of Nursing, or designee, will	

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	left the room. No alarms were ever heard during CNA #1 standing on and off the bedside mat. At 11:25 A.M., LPN #2 went in the resident's room to give her medication. LPN #2 was observed to stand on the bedside floor mat. LPN #2 rolled the bedside table across the mat and again no alarm sounded. CNA #4 came into the room to assist repositioning the resident and she stood with both feet on the floor mat. Again, no alarm sounded. The bedside table was again repositioned on the bedside mat. At 11:35 A.M., CNA #1 and LPN #3 entered to reposition the resident for lunch. LPN #3 moved the bedside table off the floor mat and then stood with both feet on the bedside mat. Again no alarm sounded. CNA #1 then repositioned the bedside table on the floor mat. LPN #3 indicated to CNA #1 the alarm should be turned back on. CNA #1 indicated the pressure alarm pad that was to be positioned underneath the resident's bottom was under her knees. LPN #3 indicated the resident didn't need the pressure alarm pad as she thought the resident only had the alarmed floor mat. CNA #1 pulled the pressure alarm pad from the bed and handed it to LPN #3. The loose wire that was lying on the floor mat was attached to this pressure alarm pad. CNA #1 then turned the alarm box on (located at the head of the bed). At 11:45 A.M., CNA #1 was interviewed. She indicated if there is pressure on the alarmed floor mat before the alarm is turned on, the alarm will not sound when it is turned on. She indicated if the alarmed mat is turned on and then pressure is applied to the mat, then the alarm would sound. On 7/12/11 at 12:20 P.M., the Wound/Skin Nurse		complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** August 13, 2011	

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	provided a current copy of the CNA (Certified Nursing Assistant) assignment sheet. This document indicated the following for Resident #19: alarm mat by bed. On 7/12/11 at 1:45 P.M., the DON (Director of Nursing) was interviewed. She indicated the resident's fall on 7/3/11 did result in a fracture to the resident's pelvis. 3.1-45(a)(2)			

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F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure stored medications in the medication room and medication cart were properly locked and were appropriately labeled during 2 of 4 medication administration observations and 1 of 7 random observations of the medication room.	F0431	**F431It is the practice of Freelandville Community Home to assure that all drugs and biologicals are secure and not accessible to residents.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified. Please	08/13/2011

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	155688	A. BUILDING 00 B. WING	07/14/2011

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	Findings include: On 7/12/11 from 10:30 A.M., until 10:55 A.M., the door to the medication room (inside the nurses station) was propped open with unlocked medications therein. The room was unattended and the nurses station door was open. The area was unsupervised throughout the time of observation. At 1:30 P.M., the contents of the room were observed to include prescription drugs(none of which were controlled category drugs) belonging to 26 residents. During interview at that time, LPN # 2 indicated the drugs were either drugs which were administered only as needed or were "extras" that would not fit on the carts. There was also an unlabeled container with 12 and 1/2 pills of various shapes, colors and sizes which were unidentified and it was not known to whom they belonged. On 712/11 at 11:15 A.M., LPN #2 was observed to prepare an insulin injection for Resident #35 and leave the medication cart unlocked and unattended in the hall. On 7/14/11 at 7:20 A.M., LPN #2 was passing medications in the dining room from the medication cart. The cart had 12 separate bins assigned to store the medications prescribed to different		refer to systems below and means of monitoring ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. The nurses/QMAs have been in-serviced related assuring that medications are secure. Please refer to systems below and means of monitoring. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The nurses and QMAs have been in-serviced related to the importance of assuring that all drugs and biologicals are locked securely unless within direct supervision of the nurse/QMA. The in-service addresses assuring that the medication cart is locked as well as the area locked where medications are stored. Nursing administration, via routine rounds will be observing to assure that medications are kept secure. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review medication carts and medication room throughout the week to assure that medications are secured properly. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then	

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	residents. In the bottom of 10 of the 12 bins there were a total of 25 loose pills and capsules of different colors, shapes, and sizes. The pills were unidentified and in several bins, and did not appear to match any of the drugs which were identified for the specific corresponding resident. On 7/14/11 at 10:00 A.M., the Administrator (HFA) was interviewed regarding the observations above. The HFA provided related policies and procedures and Pharmacy Consultant report checklists from the last quarter. The 12/14/10 Policy and Procedure for Medication Storage contained the following excerpts: "... medication room is to remain locked at all times. The door is never to be propped open. The medication cart should always be locked unless it is in direct view of the unit nurse. No medications should be left unattended ...on med carts or at the nurses station..." The Pharmacy Consultant logs from the months of April, May and June 2011 indicated the pharmacist had inspected medication room and medication carts. Recommendations, if any, were not provided. 3.1-25(j)		quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** August 13, 2011	

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	3.1-25(m)			
F0499 SS=D	The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on record review and interviews, the facility failed to ensure the active status of a Certified Nursing Assistance (C.N.A.) certification from a sample of 14 records reviewed for certification. (C.N.A. # 5) Findings include: On 7/14/11 at 10:30 A.M., the employee record for C.N.A. # 5 was reviewed. Documentation was lacking for a current Certified Nursing Assistant certification. The certification presented for review had expired on 9/21/2009. An interview with the Business Office Manager on 7/14/11 at 11:30 A.M., indicated she had printed	F0499	**F499It is the practice of Freelandville Community Home to assure that all staff that are required to have licensing or certification are routinely reviewed to assure that professional requirements remain current.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified. CNA #5 has current certification. ***Other residents that have the potential to be affected have been identified by:*** All staff that requires licensure or certification	08/13/2011

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	the certification from the Internet twice and called the C.N.A. Registry to verify active certification. Each result indicated C.N.A. # 5's certification had expired 9/21/2009. An interview with C.N.A. # 5 on 7/14/11 at 11:30 A.M., indicated she had called to be re-certified and had email instructions for steps to take to send for re-certification. Information was not provided from C.N.A. # 5 to indicate she had sent in for the certification renewal. An interview with the Administrator on 7/14/11 at 11:40 A.M., indicated the Nursing Assistant would be sent home immediately. On 7/14/11 at 11:45 A.M., the Business Office Manager indicated the Nursing Assistants were responsible to renew their own certifications online. On 7/14/11 at 12:45 P.M., the Administrator provided documentation for the Director of Nursing's Job Description. At # 12 on page 2 of the description indicated that the Director of Nursing's job summary included but not limited to, "maintain staff files up to date." The Administrator also indicated since the change from paper to computer the staff are responsible to keep their certifications up to date. 3.1-14(s)		to be employed have been reviewed to assure that all professional requirements are current. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The nurses, QMAs, and CNAs have been in-serviced related to assuring that it is their responsibility to assure that they keep their licenses and/or certifications. In addition, the facility has developed a log listing all staff members that require licensing or certification to identify expiration dates to assure that it is know if an employee is reaching an expiration date so it can be renewed prior to expiration. The log will be maintained and updated on an on-going basis. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 personnel records to assure that those employees that require licensing or certification are current. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with	

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			recommendations as needed. ***The date the systemic changes will be completed:*** August 13, 2011	